DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

NOTE TO: All Medicare+Choice Contracting Organizations

SUBJECT: Overview of Medicare+Choice 2001 Contract Year Refinements

DATE: June 8, 2000

The Health Care Financing Administration (HCFA) has been working continuously, since the creation of Medicare+Choice (M+C) in 1997, to ensure there is a wide range of health care options available to Medicare beneficiaries and to improve the operation of the M+C program for the private health plans that choose to serve them. As you begin to make final decisions about benefits and premiums for your M+C products in the next contract year, I am providing you with the 2001 contract, important information about the process to renew your participation in M+C, and background on improvements we are making to the program.

I understand your decisions regarding M+C depend largely upon an assessment of the business environment in your markets, the company's overall strategic direction, and your expected revenues from both the Medicare program and Medicare beneficiaries. As you know, by law, HCFA does not have the flexibility to modify the payment formula used to determine the government contribution on behalf of beneficiaries who participate in M+C. Enactment of the President's legislative proposal would modernize and strengthen Medicare and allow payment according to competitive market forces rather than a Congressionally-mandated formula. The plan would also create a substantially subsidized prescription drug benefit thereby providing financial assistance to both health plans and beneficiaries.

Although we cannot change current M+C payments, we have heard, and we are addressing, the concerns regarding administrative burden. HCFA is committed to using the flexibility available under the law to streamline requirements for participation by health plans while ensuring that beneficiaries who choose managed care receive the benefits, protections, and information they need and deserve. Based on your comments, we have modified many requirements in our contracts and operations to be more consistent with the approaches used by private and other public purchasers. As discussed below, we will begin a number of important initiatives that will further streamline administrative procedures for health plans and lead to more efficient and consistent oversight of your operations. Finally, we expect to release the final regulations that govern M+C in the near future. We have been actively reviewing a number of difficult policy issues, and we intend to address many of the concerns raised by M+C organizations as we continue to fulfill our shared commitment to serving Medicare beneficiaries.

The attached materials provide you with the information that you will need to renew your M+C contract for 2001. These include a sample M+C contract for 2001. In addition, there are operational policy letters (OPL) that provide guidance for completing ACR proposals, streamline the requirements for provider contracts, and that revise our current marketing guidelines. HCFA will issue a single manual for M+C operations this year and then update that manual quarterly, to replace the need for most OPLs. The following briefly discusses the enclosed documents that respond to health plan recommendations to reduce operational complexity and program uncertainty.

2001 Contract

The M+C contract has been revised to contain an assurance that no regulations or policies which create significant new operational costs will become effective prior to January 1, 2002, except where implementation during 2001 is required by statute or in connection with litigation affecting HCFA policies.

Requirements for Provider Contracts

This revised OPL (OPL 77) reduces the number of requirements that must be included in provider contracts from 23 to five -- composed of specific beneficiary protections (privacy, confidentiality and financial hold harmless), express statutory requirements (prompt payment), and express regulatory requirements (delegation). We will allow M+C organizations to determine the appropriate mechanisms for assuring provider contract adherence to other program requirements.

Renewal Instructions for the Next Contract Year

This OPL (OPL 2001) which details renewal instructions for contract year 2001, has been reduced and modified from prior versions that some plans have reviewed. New features in the ACR and Plan Benefit Package (PBP) will reduce the administrative workload for M+C organizations. In addition, these changes will help beneficiaries by improving data quality and allowing HCFA to make improvements to Medicare Compare.

Marketing Guidelines

The revised and updated marketing guidelines:

- Clarify that value added items and services can be presented in pre-enrollment marketing activity; and,

- Revise the previous policy discouraging the use of independent agents and brokers.

Final Medicare+Choice Regulations

You will recall that we published a limited final regulation in February 1999, addressing some of the most pressing concerns caused by the interim final regulation published in June 1998. We have been working hard to assure that the comprehensive final regulation provides appropriate beneficiary protections while imposing no unnecessary costs and burdens on M+C organizations. We do not plan to include any new requirements in this final rule that would entail significant new cost during contact year 2001.

In fact, the final rule would address a number of concerns that have been raised by M+C organizations, including industry requests that:

- The self-reporting provision of the compliance plan requirement be removed;
- Point of service options be permitted to include in-network providers;
- Provider network configuration need not be bound to community patterns of care;
- There be no limit imposed on the aggregate amount of cost sharing collected; and,
- There be flexibility in determining network composition and provider payment rates.

New Administrative and Policy Initiatives

We recently announced an approach to recognizing, with additional risk adjustment payments, the efforts of M+C health plans to devote resources to high quality, ambulatory programs to better manage patients with congestive heart failure. This activity is an important initiative to reward plans that improve the quality of care provided to beneficiaries. We remain committed to prompt adoption of a risk adjuster based on encounters from all ambulatory sites of service, not just hospitals, and we continue to work with M+C organizations to respond to the operational issues associated with encounter data submission. We remain committed to refining requirements as M+C organizations, providers and HCFA gain additional experience with risk adjustment payments.

A recent HCFA-sponsored conference confirmed that there are important opportunities to modify administrative procedures that affect the ability of employers to offer stable and manageable coverage for retirees in M+C organizations. For example, employers have asked HCFA to streamline the enrollment and disenrollment process for their retired employees. Employers have also asked for greater flexibility in designing benefit packages that would be available to their retirees. I have asked both the Center for Beneficiary Services and the Center for Health Plans and Providers to work with employers, unions, health plans, and beneficiary advocates to develop specific recommendations to help facilitate the participation of employers and their retirees.

I believe a very important result of the HCFA reorganization that took place in 1997 was the

creation of the Center for Beneficiary Services which allowed us to focus greater attention on HCFA's primary constituency -- Medicare beneficiaries. Nevertheless, we have learned that the reorganization dispersed the former Office of Managed Care's various functions too widely. To assure greater accountability and coordination of activities that affect health plans on a daily basis, we are working with the American Federation of Government Employees, and will propose to consolidate the various managed care functions that reside in three different parts of the Center for Health Plans and Providers into a single unit, under a single director. We will be conducting a national search for a senior executive with extensive private sector experience, preferably in health plan administration or employer purchasing, to manage this unit.

It is clear that the M+C program statutory requirements far exceed those applicable to other Federal government agencies that administer contracts with private health plans, such as the Federal Employees Health Benefits Program. However, I will ask a recognized benefits consulting firm with extensive managed care experience to conduct a comprehensive study comparing our oversight approaches with those of other large public and private purchasers, and recommendations for easing what health plans believe are excessive regulatory requirements. As part of this analysis, I will ask the firm to estimate the marginal cost of compliance with M+C requirements, an issue that has been the source of dispute. Such an analysis will help HCFA and others assess the program requirements it imposes on M+C organizations.

We thank you for your participation in M+C and look forward to working with you to ensure a wide range of choice for Medicare beneficiaries. I hope that you will continue to share your thoughts with Robert Berenson, M.D., the Director of the Center for Health Plans and Providers, as we continue our work to improve the Medicare program.

Sincerely,

/S/

Nancy-Ann Min DeParle
Administrator

Enclosures